DISTRICT OF COLUMBIA HIV IMPLEMENTATION PLAN

DRAFT

DECEMBER 1, 2012

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health

HIV/AIDS, Hepatitis, STD
and TB Administration (HAHSTA)

December 10, 2012

Dear Community Colleagues:

The District of Columbia Department of Health (DOH) is pleased to present an Implementation Plan for eliminating HIV in the District of Columbia. The Plan is comprehensive, city-wide, multi-sectorial, and community based. The District's efforts to combat HIV/AIDS in the District include government agencies that work in schools, housing, the justice system, transportation, insurance and banking, licensure, across the health system (substance abuse, mental health) and others. In order to achieve a One City vision, DOH has invested in creating a plan that will fully engage city unions and allow for the creation of partnerships with key private sector stake holders.

The Mayor's HIV/AIDS Commission requested DOH develop an implementation plan to complement the city's current structure for addressing HIV/AIDS. The Plan unifies current planning documents into one framework. It also takes another important step to align goals and objectives, and details proactive actions and next steps. The Department thanks the Mayor's Commission for making this recommendation and to Mayor Vincent C. Gray for making the call for the Implementation Plan that will improve fight against HIV in the District.

DOH conducted a thorough review of several current city-wide HIV/AIDS plans. After further review, it was determined to eliminate duplicative items and streamline goals and objectives with measurable indicators. The updated Plan contains practical actions to guide the District's response to the epidemic which is science based, comprehensive, city-wide, and incorporates strong community input. The Plan is intended to be a living document that will adjust to new gaps, services needs and be flexible to new scientific findings and program innovations.

On behalf of the DC Department of Health, I would like to personally thank the many community members who have invested their time, ideas and effort into compiling a comprehensive portfolio of planning documents, especially the Ryan White Planning Council and the Prevention Planning Group.

This is the beginning not the end of a process. We must continue to work together to engage the community, the agencies of the District government, the Federal government, and the diverse partners in the District to maintain a dynamic and evidence based approach. With this document in hand, now is the time to act. Together we can end AIDS.

Sincerely yours,

Gregory Pappas, MD PhD

Vision for the District of Columbia HIV Implementation Plan

The District of Columbia will become a place where new HIV infections are rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socio-economic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination.

Mission for the District of Columbia
HIV/AIDS, Hepatitis, STD, and TB Administration

To ensure provision of services, policies, and services that combat HIV/AIDS by:

- Preventing new infections
- Increasing access to care and optimizing health outcomes
- Reducing health disparities
- Achieving a more coordinated response combating HIV/AIDS to benefit all District of Columbia residents

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Executive Summary

The Implementation Plan took shape under the direction of the Mayor's HIV/AIDS Commission as part of an effort to encourage collaboration among the major HIV planning entities in the District of Columbia. The Plan patterns itself in part on the *Implementation Plan of the National HIV/AIDS Strategy* that has so strongly influenced the response to the epidemic in the United States. The National Strategy, which is evidence based, provided a template for much of this document and the planning effort which this document brings together. The Plan is comprehensive, city-wide, multi-sectorial, and community based. The city's efforts to combat HIV/AIDS in the District include government agencies that work in schools, housing, the justice system, transportation, insurance and banking, licensure, across the health system (substance abuse, mental health) and others. In addition, the District has sought the much needed input and support of city unions and the private sector in order to work together to create a strategy that will truly benefit communities and residents.

The District of Columbia is fortunate to have some very strong planning processes and comprehensive plans. The current plans are deeply rooted in community and federal support. The Ryan White Planning Council and the HIV Prevention Planning Group are two of the federally supported community planning bodies. In addition to federal directed planning, the District is also fortunate to have locally driven plans which address unique aspects of the epidemic in our city.

The Department prepared the Implementation Plan by respecting and drawing upon the important work the community had already done. The sources of the Implementation Plan include the HIV Comprehensive Care Plan, the Comprehensive HIV Prevention Plan, the DC Program Collaboration and Service Integration (PCSI) Plan, and DOH federal grant application plans. The complete list of source documents is listed at the end of this document. Through its CDC-funded PCSI initiative to promote a more coordinated response to the epidemic, DOH created a matrix of all the documents and grants that comprise its program portfolio. The matrix was harmonized at a senior management retreat and finalized by a team in the Department's HIV/AIDS Strategic Information Bureau.

The Implementation Plan includes over 100 goals, objectives, and actions. Both the high level and detailed views follow a common format. The Plan is presented as Goals, Objectives, Targets, Baselines, and Actions. The four overarching goals or pillars of the National Strategies are used in both views. The primary goals of the plan are to: **1) Reduce New HIV Infections; 2) Increase Access to Care and Improving Health Outcomes for People Living with HIV; 3) Reduce HIV-Related Disparities and Health Inequities; and 4) Achieve a More Coordinated Local Response to the HIV Epidemic.**

This document should be considered a living document and a tool for current and continued planning. The document will help coordinate the important planning efforts that are ongoing in the District. An on-line version of this report, which can be presented in multiple views, will also be used as a tool for future planning.

Introduction

This introduction provides a brief overview of HIV in the District of Columbia (situational analysis), reviews the major source documents for this Implementation Plan by reviewing current plans in the District, and defines the terms goals, objectives and action used. This plan is comprehensive, city-wide, multi-sectorial, and community based. This section also includes a discussion of how this Implementation Plan can be used for future planning.

Situational Analysis

The DC Department of Health reports the impact of HIV, Sexually Transmitted Diseases (STDs), viral hepatitis, and tuberculosis on the District of Columbia as a whole and by ward. Having these statistics can help communities and health care providers best plan for programs that will help reduce new infections, connect people into care and treatment, and achieve better health outcomes for our residents. The city recognizes progress is being made to diagnose people earlier in their disease; getting people quicker into medical care and reduce the chances that their disease will get worse. There is evidence that the number of new HIV cases declined city-wide, while the number of people entering medical treatment within 3 months increased. With this information in mind, the next step should focus on encouraging residents to learn their HIV, STD, hepatitis, and TB status, and to empower them to take control of their sexual health by using available HIV/AIDS and STDS services to live longer healthier lives. The next step is truly moving from promotion of available services to promotion of service utilization.

As of December 31, 2010 there were 14,465 residents of the District of Columbia diagnosed and living with HIV, representing 2.7% of all adults and adolescents in the District. The World Health Organization considers HIV prevalence of more than 1% to be a severe and generalized epidemic. In the District nearly every population and age group is experiencing a substantial epidemic. Moreover, targeted studies of HIV-related behavior indicate that between one-third and one-half of DC residents may be unaware of their infection.

Facts and Figures Regarding HIV in the District of Columbia, 2010

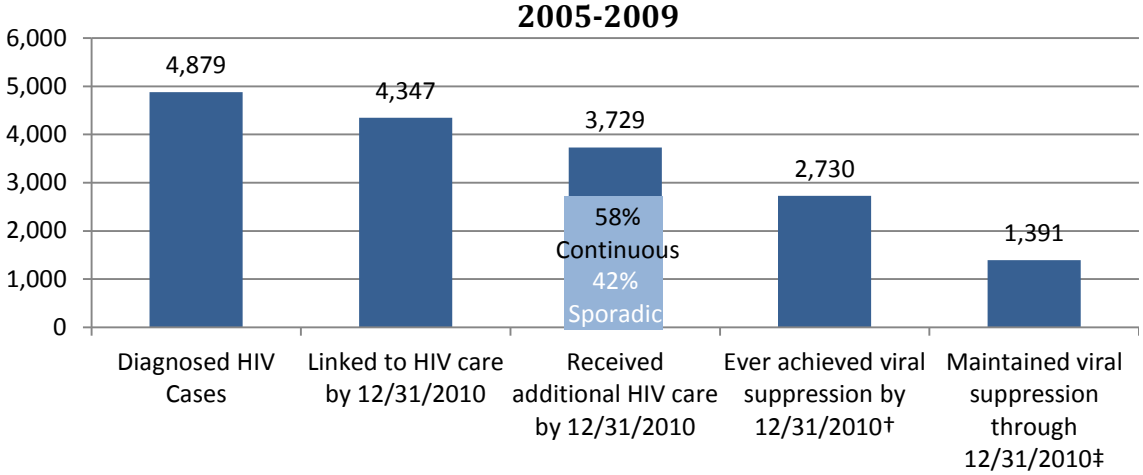
- The number of newly diagnosed HIV cases in the District decreased slightly from 853 cases in 2009 to 835 cases in 2010; however, there has been a 24% reduction from 1,103 cases in 2006.
- District residents over 40 years of age continue to be disproportionately impacted by HIV. Approximately 6.6% of residents 40-49 years of age and 5.5% of residents 50-59 years of age are living with HIV.
- Blacks still account for the majority of people living with HIV in the District. At the end of 2010, 4.3% of black residents were living with HIV. The highest burden of disease is among black men with 6.3% of black males diagnosed and living with HIV. Approximately 1.8% of Hispanic residents and 1.2% of white residents were also living with HIV.
- Almost three-quarters (72.3%) of living HIV cases were male in 2010.
- Men who have sex with men continued to be the leading mode of transmission of all HIV cases in the District. At the end of 2010, 40.5% of living HIV cases were attributed to

this mode of transmission. Heterosexual transmission accounted for 28.0% of living cases followed by injection drug use at 15.1%.

- Mode of transmission differs greatly by race/ethnicity however. While men who have sex with men is the leading mode of transmission among whites (81.0%) and Hispanics (54.1%), heterosexual contact is the leading mode of transmission among blacks living with HIV (33.7%).
- There was a 72% decrease in the number of newly diagnosed HIV cases attributable to Injection Drug Use (IDU) from 150 in 2007 to 50 in 2010. The Department of Health believes that the expansion of needle exchange programs may have resulted in this decrease in new IDU cases.
- More than 75% of HIV infected people entered into care within three months of their HIV diagnosis in 2010. The proportion of HIV cases entering care within 3 months increased by 31% between 2006 and 2010 as well.
- The median CD4 count at diagnosis increased from 355 in 2009 to 391 in 2010. Overall, the median count at HIV diagnosis has nearly doubled from 191 in 2006.
- The number of new AIDS cases decreased by 32% from 700 in 2006 to 477 in 2010.
- The number of deaths among persons with HIV decreased by half from 399 in 2006 to 207 in 2010.

Statistics representing the District of Columbia's continuum of HIV care are presented in the figure below. This snapshot or cross-sectional look examines HIV cases diagnosed within the District between 2005 and 2009 and follows their progress through the continuum of care until December 31, 2010.

HIV Continuum of Care for HIV Cases Diagnosed in the District of Columbia, 2005-2009



†At least one viral load test result prior to 12/31/2010 was <400 copies/mL.
‡All subsequent viral load test results were ≤400 copies/mL.

As depicted in the first bar on the previous page, 4,879 HIV cases were diagnosed in the District between 2005 and 2009. Approximately 89% of diagnosed cases (n=4,347) were linked to HIV

medical care by December 31, 2010. Linkage to HIV medical care is defined as having at least one CD4 count, CD4 percentage, or viral load test reported to the Department of Health.

The next bar represents cases that received additional HIV care after they were linked to care. Cases were considered to have received additional HIV care if they had at least one CD4 count, CD4 percentage, or viral load test reported to DOH after the date of their linkage to care. Under that definition 3,729 cases, or 76% of diagnosed cases, received additional HIV care before December 31, 2010. DOH further classified additional HIV care as 'continuous care' and 'sporadic care'. Continuous care is defined by the Health Resources and Services Administration (HRSA) as receiving two HIV related lab tests 10-14 weeks apart. Sporadic care, defined by DOH, includes cases that had only one additional HIV related lab reported or cases that had two or more labs reported but the labs were less than 10 weeks apart or more than 14 weeks apart. More than half, or 58%, of the 3,729 cases receiving additional HIV care were considered to be in continuous care and 42% cases met the sporadic care definition.

The next bar depicts the proportion of diagnosed cases that achieved viral suppression prior to December 31, 2010. Cases included in this bar had at least one viral load test result reported that was less than 400 copies/mL. As shown, 2,730 HIV cases, or 60% of diagnosed cases, achieved viral suppression. It is important to note that 3,693, or 76% of the cases diagnosed between 2005 and 2009, had at least one viral load test reported to DOH prior to December 31, 2010 (data not depicted above).

The last bar focuses on cases that had subsequent viral load test results after they achieved viral suppression. In this category 2,181 or 80% of the cases that achieved viral suppression had at least one additional viral load test result and could be included in this analysis (data not shown). As depicted above, 1,391 cases maintained viral suppression until December 31, 2010. Maintenance of viral suppression was defined by having all subsequent viral load results less than 400 copies/mL.

An overview of how the various pieces of the planning process work together is presented in Figure 1 below. The arrows between the various components indicate that planning in the District is highly interactive. The figure is arranged in three parts: strategic, implementation, and foundations. The foundations of the planning process in the District are the Mayor's One City Plan, the National HIV/AIDS Strategy, and the Affordable Care Act. These are the documents that all HIV planning must reflect.

The implementation components of the planning process include the many documents that direct actions of DOH and other agencies. This includes the major source documents listed at the end of this document. The strategic level of District HIV planning includes bodies that have District or federal mandates. The Ryan White Planning Council (RWPC) produces the Comprehensive Care Plan. The HIV Prevention Group reviews and makes recommendations to the Department on the DC Jurisdictional and Comprehensive HIV Prevention Plans. The Mayor's HIV/AIDS Commission helps coordinate and guide the overall process. All three of these bodies are made up of community members and constitute a city-wide response to HIV. Planning in the District of Columbia is city-wide and multi-sectorial. The goals and objectives include work with the educational system, transportation system, justice, policy, detention, housing, the business community and others.

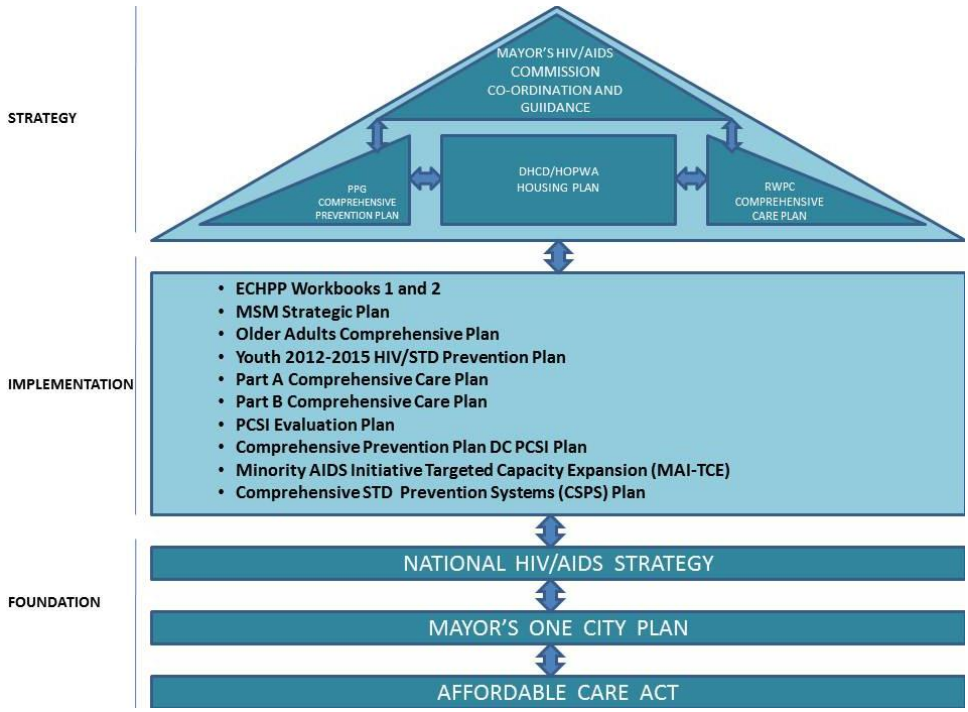
What follows is a description of the major planning processes.

Part B: DOH leads the development of annual and periodic plans for HIV care and support services. In its most recent development of the comprehensive plan, the Department drew upon the work of 'Part A' of the Comprehensive Care Plan. This part of the plan was supplemented by establishing a work group (the "DC Delegation") composed of consumers who are residents of the District of Columbia, and in many cases have an active involvement with the Planning Council.

Housing: DOH participates in the annual process managed by the DC Department of Housing and Community Development to develop plans for housing services. HAHSTA is involved in public hearings, encourages participation in the hearings by consumers and others involved in planning HIV services. Participation by consumers and advocates offers an important opportunity for the housing needs of people with HIV (and other "special needs" populations) to be discussed.

HIV/AIDS Drug Advisory Committee: DOH supports the work of a committee to advise on implementation of the AIDS Drug Assistance Program. The committee is designed to include physicians, pharmacists and other professionals to ensure a well-informed discussion of the key technical issues facing the committee. Membership includes consumers and service providers to infuse into the work of the committee sensibilities of practical requirements of service consumption and delivery.

DC HIV Planning Process



HIV Prevention Planning Group (PPG) - CDC has given new direction to HIV prevention planning though the PPG. The Department's CDC-funded HIV prevention planning process brings together key stakeholders, including community members and providers of HIV prevention, care, substance abuse and mental health services for high-risk populations to

participate in community planning and a comprehensive engagement process. DOH facilitated a larger engagement panel to make recommendations to the DC Jurisdictional and Comprehensive HIV Prevention Plans, which include a situational analysis and goals and objectives to reduce HIV transmission in the District. The PPG also determines if the prevention plans target the most affected populations and areas in the District, and submits a letter to the CDC indicating whether it concurs with the plan. Participation included an array of expertise and representation of behavioral scientists; community-based organizations; community health care centers; DC HIV Prevention Planning Group Members; faith community; HIV clinical care providers; homeless services; Local Education Agency; mental health professionals; Metropolitan Washington Ryan White Planning Council; persons living with HIV; Ryan White CARE Act funded organizations; social services, and substance use services. The PPG conducted its work in a series of public meetings over the course of the fall with excellent community attendance and participation.

The RWPC and PPG are working more closely together under the recommendation of the Mayor's Commission for HIV/AIDS and direction given by pillar four of the national strategy. Recommendations from that joint group will lead to routine reporting about planning activities to both groups to ensure better coordination.

The Mayor's Commission brings together leadership from all sectors of the city that have an impact on HIV including schools, housing, police, and the private sector. The broad purview of the Commission will be well served by bringing together the extensive planning done by RWPC, the PPG, and other planning bodies.

In addition to federally directed funding, DOH has produced some highly original planning documents to address local needs. Men who have Sex Men, Youth, and Older Adult planning documents were developed with strong community input. These documents were also incorporated into the Implementation Plan provided in this document.

HIV planning and the Affordable Care Act

The city-wide Implementation Plan comes at a very exciting time in the history of the fight against HIV and AIDS. President Obama has made two major contributions to this fight: the National HIV/AIDS Strategy and the Affordable Care Act. Strategies and guidelines from these two important federal initiatives have been incorporated into the Implementation Plan and aspects of the Affordable Care Act are already being put into action. As a result, access to health insurance will soon be available to all residents in the District with the assistance of expanded Medicaid coverage and the Health Exchange. Additional benefits of implementing health reform include improving the quality of health insurance and control costs associated with health insurance plans. Implementing the National HIV/AIDS Strategy has been made possible by leveraging funds and policy of the Affordable Care Act.

The District can expand HIV testing by encouraging health care providers to test all District residents on a regular basis. The U.S. Preventive Services Task Forces has now recommended annual HIV testing for all American following a long standing recommendation for testing by the DC Department of Health. Encouraging physicians to do this testing through education programs is also a part of the work set on in this plan. To complement routine testing in the

District of Columbia, the Department of Health will continue to encourage testing in non-clinical settings and to targeted populations. The District is a national leader in testing and the new strategy puts the District in the forefront nationally.

Regarding treatment, the District is also leading the nation by improving quality of care and controlling costs. Again, as an early adopter of the Affordable Care Act the District can implement programs and policy that will successfully provide life-saving drugs to people who are HIV infected, suppress the virus, and improve efficiency.

The Department of Health is also working with DC Health Care Finance Administration to put in place a new ADAP pharmacy network. The new network is anticipated to increase choice to consumers, improve oversight of the program, and dramatically decreased costs to the city. Reform to the pharmacy care network will make it easier for clients to move between Medicaid and ADAP in an efficient manner. The system will also allow the city to track pharmaceutical dispensing. The data system for the new network will be used to support the quality assurance program called for in this Implementation Plan.

Four Features of the Patient Centered Medical Home

- *Accessible*
- *Comprehensive*
- *Longitudinal, and*
- *Coordinated care*

in the context of families and community." (National Academy of Sciences, 1996)

Another component of the Affordable Care Act to highlight is the promotion of the HIV Patient Centered Medical Home. Medical homes are critical to help people get on anti-retrovirals and maintain viral load suppression. By providing comprehensive, continuous, coordinated family and community oriented care -- the medical homes will improve health of people living with HIV/AIDS as a whole person. The medical home is ideal for the care of all chronic diseases and as people living with HIV age they increasingly face a host of other chronic disease.

The Distinct is moving forward to promote establishment of medical homes in a number of ways. Clinics must are being encouraged to move towards accreditation as patient-centered medical homes. Medical homes are critical in coordination social services so important to their clients. To this end, DOH is working to ensure that non-clinical community based organizations are working closely with clinics to help clients stay in care and stay on medication. The patient centered medical home is a critical feature of the Affordable Care Act and he US Department of Health and Human Services is encouraging this movement through funding incentives and policy. The District is seen as a national leader in implementation of the HIV patient center medical home and has incorporated this approach into its Ryan White Comprehensive Care Plan and it the Comprehensive Prevention Plan. This Implementation Plan sets out the medical home as a key strategy to meet the goals and objectives of the District.

Definitions: Goals, Objectives, and Actions

The Implementation Plan outlines standard definition of terms to help tie together and streamline the main message of the documents used to compile The Plan. The CDC defines **goal** as a broad description of an intended outcome (performance measure). **Objectives** are targeted outcomes to achieve a goal (performance measure) and are measurable. **Action** is defined as specific course of activity that advances performance measure. The documents which comprise the Implementation Plan have used a variety of approaches to planning and definitions of terms. The Plan sorted the different terms and re-categorized them to fit into this framework. The original language of each source planning document is maintained in the original as those documents guide specific reporting activities which DOH maintains with federal partners.

(citation www.cdc.gov/about/goals)

How This Document can be Used

The Implementation Plan is a living document that is intended as a tool to guide action and promote future planning by community planning bodies, community partners, stakeholders and District government agencies. This plan will serve as a resource tool for our Ryan White Planning Council and the Prevention Planning Group as this community based planning efforts go forward. The Mayor's Commission will also use this Implementation Plan to pay its role as a coordinator of city wide efforts.

The document provides a platform to conduct a gap analysis, evaluate the strengths and weaknesses of District planning and outline methods, as well as approaches to improve the Districts efforts towards addressing HIV/AIDS. By aligning action with goals and objectives, the District can also assess if the allocation of resources matches the goals and objectives. Mathematical models to address the efficiency of expenditures have become well developed for HIV.

The Implementation plan is also intended for the use of District of Columbia community based organizations to incorporate into their own activities in such a way that they are aligned with District-wide efforts.

DOH plans to update the data base that constitutes this report as a source document to guide future planning. A more coordinated response will be achieved by this on-going effort to have all planning efforts draw from a similar set of goals, objectives, and actions. As our evidence base grows and we learn how to better fight the epidemic, the plan will change and the Implementation Plan will evolve to accommodate emerging advancements in knowledge and guidance.

District of Columbia Goals, Objectives, and Actions

This chapter provides the details of the goals, objectives and actions contained in the specific planning documents that guide the fight against HIV/AIDS in the District of Columbia. This chapter brings the content of those documents into a unified framework. The major sources of for this document are the Comprehensive Care Plan, the Comprehensive Prevention Plan, and the DHCH/HOPWA Housing Plan. These documents are the result of a planning process with the community and include several key federal agreements that help outline activities and strategies. This plan does not replace those efforts, but enables us to work together as one city to fight the HIV/AIDS epidemic.

The goals, objectives, and activities outlined provide a view of the comprehensive, multi-sectoral, and city-wide effort underway in the District of Columbia.

Reducing New Infections

1a Reduce the number of people who are unaware of their infection status

Objective 1a1 Increase the number of HIV-positive persons who know their status

By September 30, 2015 increase the proportion of individuals in the general population who indicated they were tested for HIV from 51% to 90%

Increase the median CD4 count at time of diagnosis from 361 to 500 by September 30, 2015

By September 30, 2015, increase the number of tests delivered in healthcare settings by 10% each year, from 51,043 tests in 2011 to 74,732 tests by 2015.

Increase the number of tests delivered by clinical and non-clinical providers by 5% each year from 76,161 tests in 2011 to 92,574 tests by 2015.

Activities:

- Fund six hospitals to provide testing in emergency departments and one primary care provider to provide testing as part of routine medical care
- Fund two core providers of medical/clinical services for people living with HIV/AIDS to provide testing as part of routine care
- Provide technical assistance to enhance provider skills in implementing opt-out routine HIV testing and result delivery, including how to offer the test as part of routine medical care
- Provide free rapid test kits to selected providers, and provide training on HIV testing utilizing rapid testing technologies
- Provide or secure training or technical assistance to enhance provider skills in implementing targeted testing and social networks testing

Objective 1a2 Eliminate perinatal transmission of HIV

Increase the proportion of pregnant women who are tested for HIV during their first and third trimester from 70% to 95% by September 30, 2013

Increase the proportion of women screened for HIV in labor and delivery to 95% of all deliveries by September 30, 2013

Increase the proportion of HIV-positive women of childbearing age who are in care from 80% to 91% by September 30, 2015

Activities:

- Continue to work with seven hospitals that have Labor and Delivery Suites, the DC Birthing Center, and healthcare providers to encourage both routine HIV screening and screening during pregnancy
- Continue to provide information on the need to deliver messages regarding routine screening and screening during pregnancy at clinical Grand Rounds at three hospitals

- Increase the number of Ryan White HIV medical providers offering safe pregnancy toolkits, which include a booklet for mothers that are newly identified as being HIV-positive during their pregnancy
- Provide technical assistance and education around linkage to HIV care services to labor and delivery suites, birth centers, and healthcare providers

1b Reduce the impact of risk behaviors

Objective 1b1 **Increase the number of high-risk negatives and HIV-positive individuals engaged in behavioral risk reduction interventions**

Establish new programs by April 1, 2013 to implement risk reduction interventions for at least 600 high-risk individuals per year

By April 1, 2013 fund clinical care providers to implement risk reduction interventions for at least 400 HIV-positive individuals

Activities:

- Fund up to three community-based organizations to provide HIV testing and group-level or community level evidence-based interventions for high-risk negative persons at highest risk of acquiring HIV, including Black heterosexuals, sex workers, transgender women, and Latinos
- Require that funded providers link high-risk clients to social, mental health, and substance abuse service, and have in place linkage protocols that include a written contractual agreement with a clinical care provider, preparing clients for medical care, working with clients to establish medical care appointments, following up with client, and confirming that clients attended the medical appointment
- Provide technical assistance to providers around assessment of client needs and comprehensive screening of clients
- Require that funded providers provide condoms and condom education to high-risk clients
- Provide or facilitate training and guidance on implementing interventions, including identification of target populations
- Fund up to four clinical care providers to provide behavioral risk reduction interventions for HIV-positive individuals
- Provide or facilitate training and technical assistance on implementing risk reduction interventions beyond the four funded providers
- Require that funded providers to link clients to social, mental health, and substance abuse services for HIV-positive individuals
- Facilitate linkages with CBOs that can support the retention in care process and provide support services to improve adherence
- Require that funded organizations provide condoms and condom education to HIV-positive individuals

Objective 1b2 **Expand the distribution of male and female condoms, and promote appropriate condom use among HIV-positive individuals, high-risk negatives, and the general population**

By December 31, 2015, increase the number of condoms distributed to HIV-positive individuals, high-risk negatives, and the general population by 5% each year, from 4,600,000 in 2011 to 5,591,329 by 2015

Activities:

- Continue the District-funded distribution of free male and female condoms and lubricants to individuals and organizations through HAHSTA's web-based ordering system and a network of 500 community partners
- Require that all prevention service providers provide condoms and condom education to HIV-positive individuals, high-risk negatives, and youth
- Continue the social marketing campaign to promote male and female condom use
- Increase the number of Wrap MC youth condom educators from 180 to 250, and the number of schools and community programs with Wrap MC educators from 45 to 60
- Provide or facilitate training and guidance on condom distribution, including identification of target populations
- Increase dissemination of DC specific materials promoting the appropriate use of condoms
- Use data and community input to strategically distribute condoms to high-risk populations

Objective 1b3 **Continue and expand social marketing campaigns to support prevention initiatives for persons living with HIV/AIDS and high-risk negatives**

By December 2014, expand from 2 to 5 the social marketing campaigns to support prevention initiatives

Increase the number of person impressions (persons who viewed or listened) advertisements on HIV and healthy behaviors from 30,000,000 to 45,000,000

Activities:

- Expand the reach of the consumer-driven and provider-driven social marketing components of the "Ask for the Test" and "We Offer the Test" including integration of other population groups in the campaign
- Increase the number of DC's social marketing outlets advertising and promoting safe sex through condom use from 20 to 30
- Hold focus groups involving persons living with HIV/AIDS, community based organizations, and providers to determine targeted marketing strategies, develop, test, and launch social marketing campaigns to promote prevention and treatment adherence, and provide technical assistance to providers on these topics
- Hold focus groups of consumers, PLWH, and providers to determine targeted and effective marketing strategies and develop, test, and launch a social marketing campaign that addresses stigma around homophobia, HIV testing, and disclosure.

Objective 1b4 **Establish Non-Occupational Post Exposure Prophylaxis (NPEP) and Pre-Exposure Prophylaxis (PrEP) policies and protocols for the District of Columbia**

By September 30, 2013 develop NPEP and PrEP policies and protocols for DC

Activities:

- In collaboration with the CDC, clinicians, care providers, academic partners, and other stakeholders, examine and review existing NPEP and PrEP policies and protocols
- Complete demonstration project on the feasibility of PrEP by September 30, 2014

1c Intensify prevention efforts in communities where the burden of disease is most heavily concentrated

Objective 1c2 Provide partner services for HIV-positive individuals and services for their partners

Increase the number of partners elicited from HIV-positive individuals by 5% each year from 123 in 2011 to 150 by 2015, and the number of partners notified from 45 in 2011 to 55 by 2015

Activities:

- Continue to require that all testing offer partner services to all newly positive individuals immediately upon diagnosis and attempt to elicit partner information
- Continue to require that all testing partners report partner information to HAHSTA
- DIS staff will continue to locate the partners, confidentially advise them of their exposure, and support services as necessary
- Continue to provide training on partner elicitation and encourage provider participation with the Partner Services Toolkit, which offers tips on how to start the dialogue with patients, what information to elicit, what to do with the information, and how to promote disclosure as a means of support

Objective 1c3 Engage community stakeholders in comprehensive prevention planning

By September 30, 2012 and yearly, thereafter, the HIV Prevention Planning Group (PPG) will identify and implement strategies to recruit and retain PPG members that represent the diversity of HIV-infected populations, other key stakeholders in HIV prevention and care and related services, and organizations that can best inform and support the development and implementation of a Jurisdictional HIV Prevention Plan

By September 30, 2012 HAHSTA and the PPG will develop and implement a collaborative engagement process that results in identifying specific HIV prevention strategies for the highest-risk populations; the two bodies will also identify and employ various methods to elicit input on the development of the Jurisdictional HIV Prevention Plan from HPG members, other stakeholders, and providers

By November 9, 2012 and yearly thereafter, the PPG will review the Jurisdictional HIV Prevention Plan and Comprehensive Plan and indicate whether they concur that the plan allocates resources to the most affected populations and areas

Activities:

- Identify community members, key stakeholders, and other HIV service providers involved in HIV prevention, care, and treatment services to participate in community planning and a comprehensive engagement process
- Provide orientations and trainings for new and current members on prevention planning and the HIV epidemic in DC on a regular basis
- Assess planning group membership yearly to ensure appropriate stakeholders and community representatives are included
- Implement an engagement process that results in greater access to HIV prevention, care, and treatment services for the most disproportionately affected populations and moves the jurisdiction towards a greater reduction in HIV incidence and HIV-related health disparities

- Hold engagement meetings with a broad group of stakeholders, including HIV service providers and PPG members, at least twice a year
- Provide orientations and trainings for PPG members on the engagement process and the development of the Jurisdictional HIV Prevention Plan
- The PPG will review the Jurisdictional and Comprehensive HIV Prevention Plans and submit a letter to the CDC signed by the PPG co-chairs on behalf of the PPG membership. The letter will be one of concurrence, concurrence with reservations, or non-concurrence and should be submitted to the CDC with the Jurisdictional HIV Prevention Plan

1d Establish models to more efficiently link and retain infected individuals into care

Objective 1d1 **Increase the number of HIV-positive individuals that are linked to clinical care**

By December 31, 2015 increase the number of HIV-positive individuals linked by CBOs to clinical care within 3 months of their HIV diagnosis by 5% each year, from 241 in 2011 to 292 in 2015

Activities:

- Continue to require that all HIV testing providers link HIV-positive clients to medical care and, as appropriate, supportive services
- Continue to implement the Red Carpet Entry system, which links persons newly diagnosed with HIV and known HIV positive persons who have lapsed in care to medical care within 48 to 72 hours
- Develop a plan to integrate navigation programs for optimal utilization of funds and health outcomes
- Assess challenges with linkage to care and identify best practices for implementation
- Provide data to CBOs and clinics to strengthen linkage, recapture, and retention activities

Objective 1d2 **Increase the number of partners of HIV-positive individuals elicited for screening and/or care**

Increase the number of partners elicited from HIV-positive individuals by 5% each year from 123 in 2011 to 150 by 2015, and the number of partners notified from 45 in 2011 to 55 by 2015

Activities:

- Increase the number of HIV field investigations at high incidence sites
- Assess expansion of Internet Partner Notification on HIV cases

1e Improve our surveillance system's ability to measure new infections and identify syndemic conditions

Objective 1e1 **Improve the use of client data and health information technology as a means of coordinating and improving care.**

Activities:

- Fully implement a comprehensive syndemic monitoring and evaluation client-level data system that integrates HIV, Hepatitis, STD, and TB surveillance and case management activities
- Support the adoption and full implementation of electronic medical records (EMR) by service providers, and support to ensure meaningful use of health information technology by HIV/AIDS service providers; included will be sharing of medical records among providers and with hospitals, with appropriate confidentiality protections
- Support and encourage maximum use of shared data systems within the network and between Ryan White providers and hospitals, community health centers, and other safety-net providers

Objective 1e2 **Enhance integrated laboratory service reporting and use of data for disease planning and management**

Ensure that 85% of in-jurisdiction laboratories are in compliance with DC reporting laws by December 31, 2012

By December 31, 2012, ensure that 50% of newly reported HIV cases have a CD4 count or viral load reported within 12 months of diagnosis

Activities:

- Review and revise policies on laboratory compliance with reporting requirements
- Assess technological alternatives for effective electronic laboratory reporting
- Establish a secure web portal for submission of electronic lab reports by laboratories that lack independent secure file transfer systems

Increasing Access to Care and Improve Health Outcomes

2a Immediately link people to continuous and coordinated quality care

Objective 2a1 **Improve linkage to care rates among funded providers**

Increase number of peer community health workers placed within the community setting from 0 to 3.

Increase the number of newly diagnosed individuals who enter into primary care within three months of HIV diagnosis from 59.4% to 75%

Activities:

- Collect linkage rates among providers to set a baseline for the number of clients linked from diagnosis to treatment
- Establish measurable objectives for improvement utilizing baseline information
- Establish mechanisms between testing and care that contribute to increased and better targeted HIV testing in both clinical and non-clinical settings
- Assess current navigation and linkage to care systems across funding, program and disease
- Develop a plan to integrate navigation programs for optimal utilization of funds and health outcomes
- Ensure the first medical appointment for newly diagnosed positives is scheduled within 72 hrs following initial diagnosis
- Develop a Quality Management strategy to monitor individuals linked through specialized programs
- *Increase the rates of linkage and engagement through peer navigation*

2b Strengthen retention and recapture of diagnosed individuals into care

Objective 2b1 **Establish and implement an operating model in the District that provides for coordination of care for individual PLWH, through the use of medical homes, comprehensive care centers (“one-stop shops”), and/or other mechanisms by 2014**

By September 30, 2015, increase the proportion of Ryan White clients that are in continuous care (at least two visits for routine medical care in 12 months receive two annual HIV care visits at least three months apart from 30% to 50%.

By September 30, 2015, increase the rate to 90% of HIV infected individuals eligible for treatment under Ryan White or other public insurance offered ART.

Activities:

- Establish medical homes or similar models appropriate to the District that provide for the coordination of medical care and the availability and coordination of medical-related and support services for all Ryan White consumers.
- Explore and promote strategies for establishing "Medical homes" and encourage providers that target specific populations to participate
- Explore and adopt case management refinements, renewed use of non-medical case management, and/or other procedures that enable PLWH to obtain the wraparound services (both core medical-related and support) they need to remain in medical care and adhere to treatment, whether these services are provided through Ryan White or other funding streams
- Develop connection pathway to service system
- Explore the use of peers as members of interdisciplinary clinical teams as a means of ensuring care coordination and consumer access to needed services
- Create a coordinated behavioral and clinical provider network for PLWHA
- Promote understanding of services through health literacy
- Develop a sustainability plan for the "Medical Homes" model

Objective 2b2 **Improve retention rates among funded providers**

Activities:

- Collect current retention rates to set baseline
- Establish measurable objective for improvement utilizing baseline information

Objective 2b3 **Initiate recapture activities among providers**

Expand the network of HIV providers engaged in recapture efforts from 83% to 92%.

By September 30, 2013, decrease the proportion of individuals with unmet need from 42.4% to 35.0%.

By September 30, 2013, increase the rate of HIV positive individuals returning to care after being lost to follow-up for > 6 months from 18% to 50%.

Activities:

- Review client data to determine who is out of care
- Collect active client list from sub-grantees and match with HARS database
- Conduct recapture activities and report outcomes
- Launch social marketing campaign around HIV treatment and adherence

2c Strengthen the capacity of providers

Objective 2c1 **Implement Sub-grantee Quality Improvement Plans**

Activities:

- Distribute a quality improvement plan instructions and a template to sub-grantees
- Provide technical assistance in developing quality statements, goals and objectives
- Develop an approval process for the quality improvement plan

Objective 2c2 **Improve Quality Infrastructure among Sub-grantees**

Activity:

- Support Sub-grantees in indentifying internal and external resources for quality improvement

Objective 2c3 **Identify the Critical Aspects of Care Provided by Sub-grantees**

Activities:

- Assist Sub-grantees in selecting 5-7 quality indicators to prioritize
- Provide technical assistance in identifying outcomes

Objective 2c4 **Ensure Standards of Care and Treatment**

By February 28, 2013, establish OAMC and MCM peer-to-peer program to facilitate health outcome data and improve participation in DC Collaborative to 80%

Complete targeted capacity building to 100% of clinicians on DHS standards and best practices

By September 30, 2015, increase the proportion of Ryan White -supported HIV positive clients with viral suppression (most recent viral load test within the last 12 months was undetectable) from 60% to 80%.

By September 30, 2013, increase the number of providers who perform recommended STD screenings on 85% of their HIV positive clients sampled to 100%.

By September 30, 2013, increase the percentage of HIV positive pregnant women who received prenatal care through all three trimesters by 20%.

By September 30, 2015, increase the number of HIV positive women of child bearing age who are in care from 80% to 91%

Activities:

- Expand and align Collaborative measures with HAHSTA's QI measures to streamline the reporting process and minimize the burden on our sub-grantees
- Review current guidelines on screening, risk reduction and clinical services among populations of focus to Identify gaps between integrated service approaches and guidelines.
- Establish a professional feedback system for prescribing clinicians whose prescription patterns are inconsistent with guidelines.
- Create training opportunities for HIV care providers targeting older adults
- Strengthen the service delivery system EMA-wide through targeted capacity building activities and coordination with non-CARE Act funding sources that will improve the organizational capacity of providers to reach historically underserved populations

2d Ensure holistic support of people living with chronic diseases and conditions

Objective 2d1 **Improve access to support services through collaborative efforts with APRA and DMH**

By September 30, 2015, increase the number of HIV positive individuals who are linked to mental health and substance abuse services increase by 40%

Activities:

- Introduce HIV testing/screening at APRA
- Develop joint consent forms and language standards for mental health, substance abuse, HIV Screening
- Develop connection pathways to service system through coordinated care
- Form an ongoing work group among HAHSTA, APRA and DMH.
- Develop integrated service guidelines on testing and assessment for HIV, mental health and substance use.
- Develop integrated service for treatment support of HIV positive persons with co-occurring mental health and substance use conditions.
- Assess and provide support for third-party reimbursement opportunities among HIV provider network for mental health and substance use services

Objective 2d2 **Improve the coordination of and access to HOPWA services to address housing gaps**

Increase linkages to support services that households affected by HIV receive by 20%.

By 2015, support 747 households on TBRA

By 2015, support 83 households on TBRA with security deposit assistance through Permanent Housing Placement

By 2015, increase the number of households served with STRMU to 392 households

By 2015, support 260 PLWHA in FBH by 2015

By 2015, provide housing information and referral services to 12,199 PLWHA

By 2015, provide support services to 410 PLWHA

By 2015, increase in viral suppression rates for those enrolled in HUD/housing program by an additional 15%

Activity:

- Endeavor to prevent a gap between the current capacity and the expected capacity through leveraged dollars

2e Expand our ability to monitor and evaluate health outcomes

Objective 2e1 **Improve the use of client data and health information technology as a means of coordinating and improving care**

Activities:

- Ensure the full implementation of the Maven client-level data system throughout the District
- Support the adoption and full implementation of electronic medical records (EMR) by service providers, and support to ensure "meaningful use"58 of health information technology by HIV/AIDS service providers; included will be sharing of medical records among providers and with hospitals, with appropriate confidentiality protections
- Support and encourage maximum use of shared data systems within the network and between Ryan White providers and hospitals, community health centers, and other safety-net providers

Objective 2e2 **Ensure improved health outcomes through access to comprehensive, high quality, culturally competent medical and support services**

Activities:

- Improve monitoring systems by reviewing and revising health outcome measures for service categories and overall evaluation mechanisms
- Evaluate the cost effectiveness of service delivery
- The District will improve the data collection system of the EMA in order to meet new HRSA requirements and for use in service analysis needs
- Review and revise monitoring tools to ensure that they provide aggregate and accurate information on service utilization, expenditures and quality of care
- Delineate roles and functions of Quality Management, Planning, Monitoring, and Evaluation at the Grantee, Administrative Agent and provider level to reduce redundancy in efforts and establish uniformity in operations
- Evaluate the overall health care delivery continuum of care by reviewing, revising, and implementing evaluation mechanisms
- Monitor trends on high-risk populations and other issues including increases in male-to-female transmission rates, late testers, concurrent diagnoses, hepatitis C, partner concurrency, co-morbidity, methamphetamine, substance abuse, homelessness
- Perform more detailed analysis of data and better inform the Planning Council around retention in care, lost-to-care and special populations
- Develop a comprehensive needs assessment strategy for the three- year planning period, covering an assessment of service gaps, examining out-of-care populations, emerging populations, provider inventory and provider capacity

2f Engaging community stakeholders in comprehensive care planning

Objective 2f1 **Implement collaborative planning and information sharing with prevention planning groups in the region**

Activity:

- Explore the feasibility of developing some form of shared prevention plan or agreement on collaborative prevention/testing efforts in the region, to facilitate coordination of shared responsibilities and seamless referral of newly diagnosed PLWH into care
- Work with prevention & planning bodies throughout the District to establish ongoing information sharing and collaborate on planning decisions
- Work with Prevention and care officials in the District will agree on shared operational definitions and measures that will allow for documentation and evaluation of testing and care outcomes; included are terms such as referral to care, linkage to care, treatment adherence, and retention in care

Objective 2f2 **Improve the effectiveness of the Planning Council to ensure that the system of care in the Washington D.C. EMA addresses the needs of communities affected by the disease and fulfill the legislative requirements**

Activities:

- Increase collaboration and coordination with other funding sources by filling mandated slots on the Planning Council
- Work closely with HRSA-funded technical assistance to ensure that all Planning Council activities operate according to federal requirements.
- Develop standard operating procedures and expectations for the redefined Planning Council committees and newly filled mandated slots on the Planning Council
- Establish and implement an MOU between the Grantee and Planning Council outlining responsibilities and activities.

Objective 2f3 **Strengthen working relationships among all funded Titles in the region**

Activities:

- Convene semi-annual meetings of all Titles to promote and strengthen working relationships among all Titles
- Reinvigorate local planning bodies to enhance planning and decision making processes and strengthen working relationships amongst all Titles

Reducing Health Disparities and Health Inequalities

3a Reduce disparities in morbidity and mortality

Objective 3a1 **Eliminate disparities in HIV morbidity and mortality related to race/ethnicity, age, mode of transmission, socioeconomic status, and geographic location**

Reduce absolute and relative disparities in HIV-related morbidity and mortality among disparate sub-populations

Activities:

- Routinize epidemiologic analyses of morbidity and mortality by race/ethnicity, age, mode of transmission, socioeconomic status, and geographic location to inform intervention strategies
- Increase access to centralized, continuous care via medical homes
- Use data to inform program planning and targeting of resources

Objective 3a2 **Achieve earlier diagnosis of HIV among disparate populations**

Decrease the proportion of late-testers in disparate populations

Reduce mean CD4 count at first diagnosis

Activities:

- Increase routine opt-out testing among disparate populations
- Increase rates of immediate linkage to centralized, continuous care
- Use data to inform program planning and targeting of resources

Objective 3a3 **Improve treatment adherence among disparate populations**

Decrease the proportion of individuals from disparate populations that are not adherent to HIV treatment

Activities:

- Analyze ADAP data and laboratory data to compare medication utilization and clinical conditions
- Set minimum viral load thresholds and create a red-flag system for medical providers that fail to meet thresholds
- Implement increased recapture activities to engage patients who have missed appointments after a set period of time

3b Reduce disparities in new infections

Objective 3b1 **Reduce risk behaviors among disparate populations at individual, relationship, and social network levels**

Increase the percentage of high-risk individuals who report condom use at last sex

Increase the percentage of high-risk individuals who know their partner's HIV status

Increase condom use among disparate populations

Activities:

- Conduct new studies to identify risk behaviors among various disparate populations at individual, relationship, and social network levels
- Develop outcome measures on understanding of risk among Gay/Bisexual men and other disparate populations
- Support healthy relationships by promoting candid and culturally competent conversations among partners
- Increase condom availability and accessibility
- Conduct research on the barriers to condom use

Objective 3b2 **Reduce disparities in HIV incidence by monitoring individual and community measurement of viral load in target populations**

Increase rates of viral suppression among disparate populations

Activities:

- Scale up TLC Plus (HPTN 065) 'test and treat' approach to ensure continuity of care among target populations to achieve higher rates of viral suppression
- Improve completeness of viral load data through electronic lab reporting (ELR)
- Obtain incidence and treatment data to accompany viral load data
- Conduct routine geospatial analyses to map mean CVL
- Apply methodology in high prevalence areas to target and monitor programs and interventions
- Continue to partner with CBOs to target high-risk populations for testing and outreach
- Employ targeted messaging to increase demand for routine testing

Objective 3b3 **Sustain integrated service delivery within needle exchange programs**

Increase the number of injection drug users (IDU) engaged in needle exchange programs who receive screenings for HIV, Hepatitis, and STDs by 10% annually by September 30, 2015

Activities:

- Collect monthly site reports detailing referrals to other health services
- Increase activities targeted to transgender populations and other disparate IDU groups

3c Reduce stigma and discrimination

Objective 3c1 **Increase service utilization and access to mental health, substance abuse, and HIV services**

Increase the proportion of HIV-positive individuals in need of integrated mental health and substance abuse services that are linked to these services

Activities:

- Address ethnic/racial stereotypes related to care access
- Develop an advertising and marketing campaign

Objective 3c2 **Reduce HIV-related stigma and discrimination against LGBTQ youth**

Decrease the percentage of youth who were threatened or hurt because someone thought they were gay, lesbian, or bisexual in the last 12 months from 8.4% to 4% by 2013

Activities:

- Increase support for LGBTQ youth in and out of school, and education of non-LGBTQ youth
- Provide a safe environment for LGBTQ youth to acknowledge their sexual identity
- Provide capacity among teachers, parents, and youth professionals on competency in working with LGBTQ youth
- Address issues related to age-discordant relationships among LGBTQ youth

3d Ensure population-appropriate prevention, care, and treatment

Objective 3d **Engage community stakeholders in HIV prevention planning**

HAHSTA and the PPG will develop and implement a collaborative engagement process that results in identifying specific HIV prevention strategies for the highest-risk populations

Activities:

- Implement an engagement process that results in greater access to HIV prevention, care, and treatment services for the most disproportionately affected populations and moves the jurisdiction towards a greater reduction in HIV incidence and HIV-related health disparities

Objective 3d2 **Increase linkage to care rates for HIV positive inmates released from the District of Columbia correctional system**

By September 30, 2013 increase the percentage of released HIV-positive inmates who are linked to care within 30 days from 24% to 75%

By September 30, 2014 increase the percentage of released newly-diagnosed HIV-positive inmates who are linked to care within 30 days from 20% to 90%

Activities:

- Increase the number of HIV providers that are participating providers received in jail release network from 2 to 8
- Increase the number of halfway houses and prison re-entry service programs that are providing HIV education and distributing condoms from 2 to 5

Objective 3d3 **Raise awareness of HIV-positive clients of the importance of treatment adherence with a focus on sub-populations with the highest prevalence**

By September 30, 2015, increase the prevalence of viral suppression among HIV-positive black men from 49% to 56%; among HIV-positive MSM from 52% to 65%; among HIV-positive black MSM from 40% to 47%; and among HIV-positive black women from 24.5% to 47%

Activities:

- Continue conducting research on clinical and social predictors of treatment adherence
- Partner with CBOs to facilitate linkage and re-engagement of high-risk populations to continuous clinical care

3e Improve our ability to identify disparities and measure inequalities

Objective 3e1: Implement routine analytic strategies to monitor disparities in infection, care utilization, and health outcomes among populations disproportionately affected by HIV

Produce and disseminate routine summaries evaluating absolute and relative HIV-related disparities among sub-populations in the District of Columbia

Activities:

- Collaborate with the research community in the District of Columbia through ongoing projects and structures (e.g., TLC Plus, DC CFAR) on research opportunities and the practical application of new findings
- Develop and disseminate publications summarizing targeted evaluation and research findings for diverse audiences of varying analytical expertise and understanding
- Incorporate social determinant measures into analytic efforts in order to better understand the contextual factors underlying the HIV/AIDS epidemic in the District of Columbia
- Use community viral load (CVL) to quantify disparities between sub-populations in the District of Columbia
- Continue conducting special studies designed to provide detailed information concerning the HIV epidemic within target populations beyond what can be ascertained through traditional surveillance activities (e.g., the National HIV Behavioral Surveillance (NHBS) surveys on men who have sex with men (MSM), injecting drug users (IDU), heterosexuals (HET), and the national Youth Risk Behavioral Survey (YRBS) on adolescents)
- Leverage the fully integrated surveillance system to identify co-morbid conditions and populations with high disease burden

Achieving a More Coordinated Response

4a Ensure the data and evidence drive HIV-related policies and programs

Objective 4a1 **Increase the completeness, quality, and timeliness of HIV-related surveillance data**

Activities:

- Establish appropriate protocols and processes for electronic laboratory reporting from facilities of varying technological capacities
- Routinely monitor and evaluate laboratory compliance with reporting regulations and standards in the District of Columbia
- Routinely evaluate data quality and completeness through various manual and automated data review processes
- Initiate active surveillance for all providers and/or facilities reporting more than 10 HIV/AIDS cases per month
- Develop and implement effective communication strategies to provide laboratories timely feedback concerning compliance with reporting regulations and standards in the District of Columbia
- Implement routine processes for the de-duplication of HIV/AIDS cases within surveillance data systems

Objective 4a2 **Increase the number of programs, practices, and organizations receiving technical assistance from HAHSTA in the application of surveillance, evaluation, and research findings for program and policy planning**

Activities:

- Produce targeted briefs, reports, and presentations outlining the practice, program, and policy implications of analytic findings from surveillance, evaluation, and research activities
- Institute mechanisms to provide timely feedback to providers, practices, and programs regarding performance metrics in order to facilitate improvements in the provision of prevention, care, and treatment services

Objective 4a3 **Increase the provision of timely information to local and federal stakeholders concerning HIV infection, care utilization, and health outcome patterns within the District of Columbia**

Activities:

- Produce and distribute a comprehensive epidemiologic profile documenting HIV/AIDS infection, care utilization, and health outcome patterns in the District of Columbia annually

- Coordinate presentations with area community groups, organizations, and planning councils to provide information on relevant local and national surveillance, evaluation, and research findings
- Develop and disseminate publications summarizing targeted evaluation and research findings for diverse audiences of varying analytical expertise and understanding
- Institute efficient processes to accurately respond to custom data requests from local and federal stakeholders and mechanisms for ensuring appropriate data interpretation

Objective 4a4 **Implement effective workforce development strategies regarding clinical guidelines and model practices for screening, risk reduction, navigation, care, treatment, and partner services to support community providers**

Activities:

- Consult with community providers on current practice and support needs for enhanced services
- Routinely identify and disseminate information concerning best practice models for meeting identified general and targeted population needs with regards to HIV prevention, care, and treatment
- Develop and support training opportunities to promote awareness and uptake of emerging HIV prevention, care, and treatment models among community providers

4b Increase the coordination of HIV, Hepatitis, STD, and TB prevention, care, and treatment planning and programs

Objective 4b1 **Fully implement a comprehensive syndemic monitoring and evaluation data system that integrates HIV, Hepatitis, STD, and TB surveillance and case management activities**

Activities:

- Develop policies for reporting of client level data into DC-PHIS system
- Develop legal policies and logistical protocols for data sharing across agencies, facilities, and/or providers
- Provide training and ongoing support to DC-PHIS end-users concerning the utilization of the system for data entry, case management, and surveillance
- Complete a comprehensive evaluation of DC-PHIS functionalities and end-user acceptability

Objective 4b2 **Fully implement a horizontal matrix management approach within HAHSTA to stimulate new program approaches and maximize synergies in workforce expertise across program areas**

Activities:

- Adapt the four pillars of the National HIV/AIDS Strategy to incorporate Hepatitis, STDs, and TB

- Form organizational teams on the four pillars of the National HIV/AIDS Strategy to review relevant data, prioritize service areas, and develop work plans to implement integrated and collaborative program approaches
- Develop evaluation process to assess effectiveness of program collaboration and service integration models among HAHSTA programs

Objective 4b3 **Increase the number of opportunities and mechanisms for continual cross-organizational communication and planning concerning HIV, Hepatitis, STD, and TB related needs and opportunities within the District of Columbia metropolitan area**

Activities:

- Engage community stakeholders in the evaluation, coordination, and development of HIV-related service systems in the District of Columbia through the Mayor's Commission on HIV/AIDS
- Form an ongoing work group among HAHSTA, the Addiction Prevention and Recovery Administration (APRA), and the Department of Mental Health (DMH) to develop integrated approaches for HIV/AIDS, mental health and substance use services
- Develop collaborative work group among HAHSTA, APRA, the Community Health Administration (CHA), and community partners for ongoing adolescent health planning and program development
- Form a joint work group with membership from HIV Prevention Community Planning Group, Metropolitan Washington Regional Health Services Planning Council, Metropolitan Washington Council of Governments, and government and prevention planning representatives from Maryland and Virginia to assess the feasibility of a regional, integrated prevention and treatment plan
- Establish a Ryan White provider work group to assess treatment coverage of people living with HIV/AIDS
- Form population-based work groups to address cultural competency and effective prevention strategies
- Complete asset mapping process to better understand potential relationships and synergies between providers, practices, organizations, community groups, and neighborhood institutions

4c Improve HAHSTA fiscal and operational efficiencies and accountability

Objective 4c1 **Realign prevention, care, and treatment service systems across the syndemic to optimize service integration, cost efficiency, and program effectiveness**

Activities:

- Assess current prevention, care, and treatment systems across funding, program, and disease, with a particular focus on duplications and cost inefficiencies
- Identify crossover in the care systems accessed by target populations through the utilization of integrated surveillance system

- Evaluate potential impacts of prevention, care, and treatment systems integration on the quality, effectiveness, and cost of services
- Develop and promote integrated service models that optimize funding utilization and health outcomes

Objective 4c2 **Increase third party reimbursement opportunities for HIV-related services within the District of Columbia**

Activities:

- Consult with Department of Healthcare Finance, DC Primary Care Association, and other relevant entities on requirements for third party reimbursement
- Determine the compatibility of community partners providing HIV-related services with third party reimbursement options
- Implement legislation in the District of Columbia regarding reimbursement of HIV screening in emergency department settings

4d Assess the efficacy, cost effectiveness, and impact of HIV-related programs

Objective 4d1 **Increase the application of performance based metrics in the evaluation and monitoring of grant funded HIV-related services and programs**

Activities:

- Identify appropriate process and outcome measures and data sources for assessing the effectiveness of funded programs in screening, linkage to care, care engagement, and treatment activities
- Incorporate cost-benefit analysis efforts into the evaluation of grant funded programs
- Implement a standard data collection and review protocol to identify Ryan White funded HIV providers with a low proportion of HIV positive patients in treatment that have achieved viral suppression

Objective 4d2 **Implement routine analytic strategies to monitor infection, care utilization, and health outcome patterns within the District of Columbia**

Activities:

- Produce timely descriptive and analytic statistics concerning HIV-related indicators in order to inform disease interruption strategies
- Conduct geospatial analysis of surveillance data to identify potential geographic areas for targeted resource allocation
- Incorporate social determinant measures into analytic efforts in order to better understand the contextual factors underlying the HIV/AIDS epidemic in the District of Columbia
- Conduct special studies (eg, NHBS) designed to provide detailed information concerning the HIV epidemic within target populations beyond what can be ascertained through traditional surveillance activities

- Engage in enhanced data use strategies to support activities related to partner services, linkage to care, and care re-engagement

4e Expand innovative partnerships

Objective 4e1 **Identify and support research to devise effective program collaboration and service integration models and support the implementation of scalable interventions**

Activities:

- Collaborate with the research community in the District of Columbia through ongoing projects and structures (eg, TLC Plus, DC CFAR) on research opportunities and the practical application of new findings

Resource Documents

2012-2015 Comprehensive Plan & Statewide Coordinated Statement of Need for DC

DC Comprehensive HIV Care Plan 2012-2014

DC Comprehensive HIV Prevention Plan 2012-2015

DC Comprehensive STD Prevention Systems (CSPS) Plan

DC Jurisdictional HIV Prevention Plan 2012-2015

DC Program Collaboration and Service Integration (PCSI) Plan

DC Youth 2012-2015 HIV/STD Prevention Plan

HAHSTA Annual Report 2011

HAHSTA-Wide Quality Improvement Framework and Quality Improvement Plan.

Minority AIDS Initiative Targeted Capacity Expansion (MAI-TCE)

National HIV/AIDS Strategy (NHAS), 2010

NHAS Implementation Plan, 2010

Strategic Plan for Reducing HIV/AIDS among Gay and Bisexual Men in the District of Columbia

DC Enhanced Comprehensive HIV Prevention Plan

DHCH/HOPWA Housing Plan

These Resources will be available on the HAHSTA Website at www.doh.dc.gov and at the HAHSTA office by calling (202) 671-4900.

Government of the District of Columbia
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HIV/AIDS, Hepatitis, STD, and TB Administration (HAHSTA)
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